

## § 421.103

(2) Make studies of the effectiveness of those procedures and recommend methods to improve them;

(3) Evaluate the results of utilization review activity; and

(4) Assist in the application of safeguards against unnecessary utilization of services.

(e) *Resolution of cost report disputes.* The intermediary must establish and maintain procedures approved by CMS to consider and resolve any disputes that may result from provider dissatisfaction with an intermediary's determinations concerning provider cost reports.

(f) *Reconsideration of determinations.* The intermediary must establish and maintain procedures approved by CMS for the reconsideration of its determinations to deny payments to an individual or to the provider that furnished services to the individual. The QIO performs reconsideration of cases in which it made a determination subject to reconsideration.

(g) *Information and reports.* The intermediary must furnish to CMS any information and reports that CMS requests in order to carry out its responsibilities in the administration of the Medicare program.

(h) *Other terms and conditions.* The intermediary must comply with all applicable laws and regulations and with any other terms and conditions included in its agreement.

(i) *Dual intermediary responsibilities.* With respect to the responsibility for service to provider-based HHAs and provider-based hospices, where the HHA or hospice and its parent provider will be served by different intermediaries under § 421.117 of this part, the designated regional intermediary will process bills, make coverage determinations and make payments to the HHAs and hospices. The intermediary serving the parent provider will perform all fiscal functions, including audits and settlement of the Medicare cost reports and the HHA and hospice supplement worksheets.

[45 FR 42179, June 23, 1980, as amended at 48 FR 7178, Feb. 18, 1983; 49 FR 3659, Jan. 30, 1984; 51 FR 43198, Dec. 1, 1986; 53 FR 17944, May 19, 1988; 54 FR 4026, Jan. 27, 1989]

## 42 CFR Ch. IV (10-1-06 Edition)

### § 421.103 Options available to providers and CMS.

(a) Except for hospices (which are covered under § 421.117), a provider may elect to receive payment for covered services furnished to Medicare beneficiaries—

(1) Directly from CMS (subject to the provisions of paragraph (b) of this section); or

(2) Through an intermediary, when both CMS and the intermediary consent.

(b) Whenever CMS determines it appropriate, it may contract with any organization (including an intermediary with which CMS has previously entered into an agreement under § 421.105 and § 421.110 or designated as a regional or alternative regional intermediary under § 421.117) for the purposes of making payments to any provider that does not elect to receive payment from an intermediary.

[49 FR 3659, Jan. 30, 1984; 49 FR 9174, Mar. 12, 1984]

### § 421.104 Nominations for intermediary.

(a) *Nomination by groups or associations of providers.* (1) An association of providers, except for hospices, may nominate an organization or agency to serve as intermediary for its members.

(2) The nomination is not binding on any member of the association if it notifies CMS of its nonconcurrence with the nomination.

(3) The nomination must be made in writing, to CMS, and must—

(i) Identify the proposed intermediary by giving the complete name and address;

(ii) Include, or furnish as an attachment, the name, address, and bed capacity (or patient care capacity in the case of home health agencies) of each member of the association;

(iii) List the members that have concurred in the nomination of the proposed intermediary; and

(iv) Be signed by an authorized representative of the association.

(b) *Action by nonmembers or non-concurring members.* Providers that non-concur in their association's nomination, or are not members of an association, may—

## Centers for Medicare & Medicaid Services, HHS

## § 421.110

(1) Form a group of 2 or more providers for the specific purpose of nominating an intermediary, in accordance with provisions of paragraph (a) of this section;

(2) Elect to receive payments from a fiscal intermediary with which CMS already has an agreement, if CMS and the intermediary agree to it (see § 421.106); or

(3) Elect to receive payment from CMS as provided in § 421.103.

(c) CMS is not required to enter into an agreement with a proposed intermediary solely because it has been nominated.

[45 FR 42179, June 23, 1980, as amended at 48 FR 56035, Dec. 16, 1983; 49 FR 3659, Jan. 30, 1984]

### § 421.105 Notification of action on nomination.

(a) CMS will send, to each member of a nominating association or group, written notice of a decision to enter into or not enter into an agreement with the nominated organization or agency.

(b) Any member of a group or association having more than one nominated intermediary approved by CMS to act on its behalf must withdraw its nomination from all but one or exercise the option provided in § 421.103(a), subject to § 421.103(b), to receive payment directly from CMS.

[45 FR 42179, June 23, 1980, as amended at 49 FR 3660, Jan. 30, 1984]

### § 421.106 Change to another intermediary or to direct payment.

(a) Any provider may request a change of intermediary, or except for a hospice, that it be paid directly by CMS, by—

(1) Giving CMS written notice of its desire at least 120 days before the end of its current fiscal year; and

(2) Concurrently giving written notice to its intermediary.

(b) If CMS finds the change is consistent with effective and efficient administration of the program and approves the request under paragraph (a) of this section, it will notify the provider, the outgoing intermediary, and the newly-elected intermediary (if any) that the change will be effective on the

first day following the close of the fiscal year in which the request was filed.

[45 FR 42179, June 23, 1980, as amended at 49 FR 56036, Dec. 16, 1983; 49 FR 3660, Jan. 30, 1984]

### § 421.110 Requirements for approval of an agreement.

Before entering into or renewing an intermediary agreement, CMS will—

(a) Determine that to do so is consistent with the effective and efficient administration of the Medicare program;

(b) Review the performance of the intermediary as measured by the criteria (§ 421.120) and standards (§ 421.122); and

(c) Determine that the intermediary or prospective intermediary—

(1) Is willing and able to assist providers in the application of safeguards against unnecessary utilization of services;

(2) Meets all solvency and financial responsibility requirements imposed by the statutes and regulatory authorities of the State or States in which it, or any subcontractor performing some or all of its functions, would serve;

(3) Has the overall resources and experience to administer its responsibilities under the Medicare program and has an existing operational, statistical, and recordkeeping capacity to carry out the additional program responsibilities it proposes to assume. CMS will presume that an intermediary or prospective intermediary meets this requirement if it has at least 5 years experience in paying for or reimbursing the cost of health services;

(4) Will serve a sufficient number of providers to permit a finding of effective and efficient administration. Under this criterion no intermediary or prospective intermediary shall be found to be not efficient or effective solely on the grounds that it serves only providers located in a single State;

(5) Has acted in good faith to achieve effective cooperation with the providers it will service and with the physicians and medical societies in the area;

(6) Has established a record of integrity and satisfactory service to the public; and